

**Mississippi State Board of Medical Licensure**  
**Pain Management Clinic Application for Registration and Renewal**  
**Appendix E**

<b>Primary Physician Owner Information</b> <small>Please mark with N/A if not applicable</small>		
Primary Owner / Operator (Name as Recorded on Medical License)		
Mississippi Medical License Number	DEA Controlled Substance Registration Number	Federal Tax ID Number
Medical School Attended:		
List all Training you have completed in any of the following: Internship, Residency, Fellowship or Specific Board Certification. For Physician Owners previously approved for the fiscal year 2012-13, please list only new training since last report.		
Mailing address of Physician / Owner (if different from clinic)		
Physician / Owner Email address		
Physician / Owner Phone Number(s)		
Number of hours Physician / Owner will be on site at this clinic per week: (List days and time)		

**Contact Information:**

If you have any questions, please Contact the Investigative Division of the Mississippi State Board of Medical Licensure at: 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS 39216 Fax: (601) 987-6822 Tel: (601) 987-0231.

Mail Forms: **MSBML/ Investigative Division - Pain Clinic Regulation**, 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS 39216. Submit original signed documents only. NO facsimile, email or duplicate copies will be accepted.

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Documentation of ownership: Please mark and include with application	<input type="checkbox"/> Sole Proprietor - IRS Tax Form 1040, Schedule C <input type="checkbox"/> Corporation - IRS Tax Form 1120 or 1120S, Federal & State <input type="checkbox"/> Partnership - IRS Tax Form 1065 <input type="checkbox"/> Other document
<b>Do you currently hold an active, unrestricted medical license in Mississippi?</b> <div style="float: right;"> <input type="checkbox"/> Yes  <input type="checkbox"/> No         </div> <p style="margin-top: 5px;">If the answer to this question is "no", you are not currently eligible to own and operate a pain management clinic.</p>	
<b>Are all the owners of the pain management clinic physicians?</b> <div style="float: right;"> <input type="checkbox"/> Yes  <input type="checkbox"/> No         </div>	
<b>Have you, any co-owner, current employee or person with whom you contract for services ever:</b> <div style="margin-top: 10px;"> <div style="display: flex; justify-content: space-between;"> <div>been denied, by any jurisdiction, a license issued by the Drug Enforcement Administration (DEA) under which the person may prescribe, dispense, administer, supply or sell a controlled substance or other listed medications under definitions?</div> <div> <input type="checkbox"/> Yes  <input type="checkbox"/> No           </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>held a license issued by the Drug Enforcement Administration under which the person may prescribe, dispense, administer, or supply or sell a controlled substance that has been restricted?</div> <div> <input type="checkbox"/> Yes  <input type="checkbox"/> No           </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>been subject to disciplinary action by any licensing entity for conduct that was a result of inappropriately prescribing, dispensing, administering, supplying or selling a controlled substance?</div> <div> <input type="checkbox"/> Yes  <input type="checkbox"/> No           </div> </div> <p style="margin-top: 10px;">If the answer to any of the above questions is "yes", you are not currently eligible to own or operate a pain management clinic.</p> </div>	
<b>Have you, or any co-owner, ever been convicted of, pled nolo contendere to, or received deferred adjudication for:</b> <div style="margin-top: 10px;"> <div style="display: flex; justify-content: space-between;"> <div>an offense that constitutes a felony?</div> <div> <input type="checkbox"/> Yes  <input type="checkbox"/> No           </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>an offense that constitutes a misdemeanor, the facts of which relate to the distribution of illegal prescription drugs or a controlled substance?</div> <div> <input type="checkbox"/> Yes  <input type="checkbox"/> No           </div> </div> <p style="margin-top: 10px;">If the answer to any of the above questions is "yes", you are not currently eligible to own or operate a pain management clinic.</p> </div>	
<p>I certify that the information that I have provided on this application is correct. I understand that it is a violation of the Mississippi Medical Practice Act, Miss. Code Ann. Section 73-25-1 et seq., to submit a false or misleading statement to a governmental agency. I acknowledge that the Mississippi State Board of Medical Licensure (MSBML) is not authorized to issue a pain management certification if I do not provide all requested information. I certify that I am the person named in this document and all statements made and information contained within my application are true and correct.</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>Physician Signature:</div> <div>Date:</div> </div> <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	

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<b>Pain Management Clinic Information</b> <small>Please mark with N/A if not applicable</small>		
Corporate or Legal Name of Pain Clinic:		
Pain Clinic Registration Number as issued by the Mississippi State Board of Medical Licensure:		
Physical Address of Pain Clinic (no post office box):		
Mailing Address of Pain Clinic:		
Phone Number(s) of Pain Clinic :		
Designated Contact Person(s) Name and direct phone number:		
Hours of Pain Clinic Operation (List days and time the clinic is open):		

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Physician and Non-Physician Information (Please Print or Type)

List All Individuals who may be clinic owner(s), principal(s), Officer(s), agents(s), managing employee(s), contract employee(s) and affiliated person(s) - use additional copies of this form if necessary.

List All Practitioners/Employees treating Pain Clinic Patients  
(Provide practice specific protocols if Nurse Practitioners are listed)

\*\*Please mark with N/A if not applicable

Name			Employee Type or Title		
List professional degree if applicable					
Professional License Number	DEA Controlled Substance Number	Date of Birth	Social Security Number		
Phone Number(s)					
Name			Employee Type or Title		
List professional degree if applicable					
Professional License Number	DEA Controlled Substance Number	Date of Birth	Social Security Number		
Phone Number(s)					
Name			Employee Type or Title		
List professional degree if applicable					
Professional License Number	DEA Controlled Substance Number	Date of Birth	Social Security Number		
Phone Number(s)					
Name			Employee Type or Title		
List professional degree if applicable					
Professional License Number	DEA Controlled Substance Number	Date of Birth	Social Security Number		
Phone Number(s)					

\*Copy this page to add additional employees if needed.